EXHIBIT F

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION
CASE NO. 4:13-CV-00800-SRC

MARY BAYES AND PHILIP BAYES,

Plaintiffs,

-vs-

BIOMET, INC., BIOMET ORTHOPEDICS, LLC, BIOMET U.S. RECONSTRUCTION, LLC, BIOMET MANUFACTURING, LLC f/k/a BIOMET MANUFACTURING CORP.,

Defendants.
_____/

VIDEOTAPED DEPOSITION OF
GEORGE S. KANTOR, M.D.

Monday, May 4, 2020
9:03 a.m. - 5:47 p.m.

BY VIDEOCONFERENCE

Stenographically Reported By:
Dianelis Hernandez

Page 78

Exhibit 4. So it will pop up in your folder. This is a list of prior testimony that your counsel gave to me last week.

MS. BUSBY: So if, Tiffany, you could mark as Exhibit 4 for me, and then everyone will want to hit refresh and you'll see the PDF pop up.

(Defense Exhibit No. 4 was marked for identification.)

BY MS. BUSBY:

Q. Do you see Exhibit 4, Dr. Kantor?

A. I do not.

Q. Have you hit the refresh button?

A. Where is the refresh button here?

MR. WOOL: It will be at the top of the browser, looks like a little circle with an arrow, looks like it's going around and around.

THE WITNESS: Got you. Okay.

A. Okay. And then click to the -- do you want exhibit -- are we now to 0004?

BY MS. BUSBY:

Q. Yes, sir, we are.

A. Okay.

Q. And I will represent to you, sir, that we served a notice of deposition and your counsel provided this list to me in response. Did you prepare this list?

Page 79

A. I -- well, I think it was prepared -- no, I didn't prepare it. It was prepared in my office by my office manager. I asked her to prepare it.

Q. Okay. And, sir, do you know the time frame for this list? Are these depositions for all time or for a certain period of time?

A. I believe that they -- I was instructed that I needed, I think, depositions for five -- four- or five-year period. This is basically, you know, for that time period.

Q. Okay. Very good.

I want to ask you a couple questions about these, sir. I know you testified before about the role you had in the DePuy litigation, so I don't belabor that. I just want to see if I can get a timeline, okay?

So number one, you provided deposition and testimony in the David E. Kauthen v. DePuy Orthopedics case. My first question is: Was it deposition testimony only or did you also testify at trial?

A. That's only deposition.

Q. Okay. Do you recall what year that happened -- that testimony was given?

A. I believe that was either 2015, 2015, 2016. I think it's 2015. That's David Kauthen was my patient. And then that deposition morphed into the DePuy

Page 80

litigation with the MDL, the combination of both the Pinnacle and the ASR prior to the recalls.

Q. Okay.

A. So that's deposition testimony. There were multiple depositions both patient specific as well as related to their ASR and Pinnacle platforms.

Q. Okay.

A. Multiple depositions on multiple days, separate periods.

Q. Okay. And, sir, you said that Mr. Kauthen was your patient, were you testifying as a treating physician or an expert witness or both?

A. As both.

Q. Do you recall how many depositions were given? I know you said there were several, but do you know how many?

MR. WOOL: Object to form.

A. I think that there were -- I think that there were two separate days of deposition related to Kauthen. Then there were three depositions scheduled for Pinnacle and ASR. They kind of went back and forth with those two things interchangeably with the defense team, and after the second complete day of deposition -- they were arduous. They were from 8:00 in the morning to 5:00 in the evening, maybe even one went to 6:00 -- after the

Page 81

first two days, they were scheduled for three days, and apparently the -- after the second full day of testimony they canceled the third day and I think that was the major massive settlement that they had.

BY MS. BUSBY:

Q. Okay. And then the deposition and trial testimony in McDonald v. Zimmer; do you recall when that was?

A. I would say that that was probably '17. I actually had to go to New Mexico for that trial.

Q. And was --

A. That was deposition plus trial testimony. So that's one of the few trials I've actually attended.

Q. Okay. And was that a metal-on-metal device, sir?

A. That was a mix metal -- that was a Zimmer mix metal trunnion issue, metallosis related to a trunnion as opposed to metal-on-metal bearing surface metallosis.

Q. Okay. And the next one, deposition and trial testimony, Frank Bifano, I may not be saying that right, versus DePuy in the Superior Court of New Jersey; do you know when that one occurred?

A. I don't have a specific date on that, and that was just a deposition. The trial was canceled. I

Page 142

the articulation itself in an asymptomatic patient just coming in for a routine follow-up of a metal-on-metal bearing surface. But we would follow that patient on a regular basis having an established MRI.

We also, obviously, know that there is a significant portion of 51 plus percent of the patients who have positive MARS reduction sequence MRI that are asymptomatic. And I think that that's really the crux of where we are with this whole issue. We are finally starting to understand how to deal with this to prevent complication or worsening of complications down the road.

BY MS. BUSBY:

Q. Okay. Well, thank you. I appreciate that.

My next question that follows along that is at what point do you make the determination that the patient does need that hip aspirate, is it the positive MRI?

A. Yes. If you have -- the algorithm is pretty clear to me. And, you know, I don't mean to sound like I was so prescient that I understood it because so many people taught me along the way. But the baseline evaluation would be the MRI, okay, but obviously you are doing plain X-ray serology, you are doing the MRI.

If the MRI comes back positive in the asymptomatic patient, we had tendency in the past to

Page 143

establish some false ion levels. So you could go to these meetings, and it was infuriating to me because you would see these supposed leaders that were up there saying, well, you could have a cobalt level of seven if it's bilateral or five if it's unilateral. But if the patient is asymptomatic don't worry about them, follow them until they become symptomatic.

Now we clearly understand, and in the past six months from the registry data, what has come back from the results for re-revision. Now we now know that if you have a positive MRI in the asymptomatic patient, you are better off -- in other words, the positive MRI I'm describing is an organized cystic pseudotumor, okay, that you should operate on before as opposed to after.

In other words, the recommendation now is to operate on that patient before they become symptomatic because by the time they become symptomatic the patient is having damage to the abductor mechanism and the soft tissues and the capsules that control the stability -- that give you the stability of the hip.

So that is the key. I think that's the biggest thing that's come out in the past six months to a year, is to finally recognize that sooner as opposed to later. And the results have proven that the sooner you get in there the better you are able and the more you are

Page 144

able to save the abductor function.

I submitted to you through photographs from MRI that follow that course of the patient. If the patient was symptomatic but relatively mildly so intervenes relatively quickly before the abductor is done and you can see that I'm surgically able to remove it and get the tumor out.

You can almost look at it as if you had -- if you had a colonoscopy with a lesion, with a tumor there, you would not say, well, it's asymptomatic. Somebody came in for a routine colonoscopy and we found a lesion there, and the patient says, well, I don't feel any different. You say, okay. Well, we'll just follow it. No, that's not what you do. You take the lesion out before it causes obstruction. That's where we are at with this situation; albeit, it is not a carcinoma or malignancy, although it's a destructive lesion.

Q. Okay. Dr. Kantor, do you have any criticisms of the way that the physicians at Washington University and the Mayo Clinic evaluated the ion levels for Ms. Bayes in this case?

MR. WOOL: Object to form.

A. The ion levels?

BY MS. BUSBY:

Q. Yes, sir.

Page 145

A. No. Because if you go back, and I'm just looking at my little chart here with my dates. You know, in fairness, the index procedures were done in January 8th -- in January 2008. At the time of the revision procedures, I think that Dr. Lux at least had an understanding that he was dealing with metallosis, with metal disease emanating from the hip articulation. But our first recall -- the first recall with Zimmer's Durom was in 2008.

So the physicians here are, you know, the physicians here in a timeline, you know, this is their understanding of the process. Your question is specifically to metal ions. I don't see, you know, I would be more intellectually curious to want to follow the metal ions every year even though the hips -- the metal-on-metal articulation -- but that's just before my understanding in a relatively young patient where you are with that.

Obviously, you are not going to do a repeat aspiration of the hip articulation and run the risk. But we like to see the -- we continue even after we take the metal-on-metal hips out, we continue to follow and track the ion levels in the serum; albeit, it is not perfect, but it does give an idea what's happening systemically.

Q. Okay. Moving along to page 17 of your

A. I have not. I've never met the man. I know people that know him because he was a few classes ahead of me, but I have never personally met him. He has a good reputation.

Q. Okay. There are a few other experts that the plaintiffs have designated in this case, and I'm just trying to move things along here. Have you talked to any other experts that have been designated by the plaintiffs in this case about this case?

MR. WOOL: Object to form.

A. Who are the -- I don't know who the experts are other than the two you mentioned previously.

BY MS. BUSBY:

Q. Sure. Let me go ahead and give you some names and you can let me know whether you have talked to any of these folks. How about Ms. Mary Truman?

A. No.

Q. Dr. Francis Gannon?

A. No.

Q. Dr. Toback, who I believe to be an economist?

A. No.

Q. Mr. Succarello who prepared a functional capacity evaluation?

A. No.

Q. Ms. Corwin, who prepared a future needs assessment?

A. No.

Q. Did you review any of the reports that those individuals provided in this case in the development of your own opinion?

A. I did not.

Q. You just saved us a whole page worth of questions, Dr. Kantor.

We talked about Dr. Lux, do you know Dr. Martin independently?

A. I do not.

Q. Do you know Dr. Mudd?

A. I do not.

Q. Do you know Dr. Nunley?

A. I do not.

Q. Do you know Dr. Lewallen?

A. I've met Dr. Lewallen in the past in conference meetings, but I don't know that -- it's probably been 10 years ago, and I don't know that I would recognize him to talk to him if he walked by me.

Q. Okay. Is there anything that you wanted to do in formulating your opinion in this case that you were not able to do, Dr. Kantor?

MR. WOOL: Object to form.

A. I mean, I would -- just more as a point of -- because I think patient, unfortunately, where she is clinically is sort of complete, I would like to see the patient. I mean, I would always like to evaluate patients and -- to do a gait analysis study on her to confirm maybe a little more detail what has been done, to do a true formal gait analysis.

But other than that I don't think there is anything. That would be more for intellectual curiosity as opposed to be able -- even if I evaluated her, I don't know that I can necessarily offer her anything. Matter of fact, I could not offer her anything. There is only one surgical solution that would even be considered, and I wouldn't consider it now.

BY MS. BUSBY:

Q. Briefly, sir, what is that one surgical solution?

A. Well, she's had a dislocation, I believe her last dislocation was in May, I believe, in 2009. So, you know, basically she hasn't had a dislocation for year. If in point of fact she dislocated and then subsequently continued to dislocate in the numerically quantitatively, the way she was dislocating up to this point in time, I think the only thing you can possibly even consider, and I almost mention it to condemn it, is

to a resection arthroplasty and take everything out.

Because the problem, she is very fortunate that she has not had an infection with this amount of necrosis, and the amount of surgical interventions she's had, and the amount of trauma she's had. And the only other thing that you -- I don't think there is anything you can offer this patient surgically.

So that leads me to the point that what do you do when she does the next dislocation? And it's a very difficult choice that her and her family, unfortunately her son is a physician, will have to make. To continue to reduce it, because you always run the risk in these cases when you open them whether you are doing a revision or you are doing a resection of getting an infection. I think that's the last thing you would want to so because it will probably end up killing her.

Q. And no one has talked about performing a resection arthroplasty at this point, correct?

A. You know, I mention it almost to condemn it because it's -- you know, we discussed it, my partner and I discussed where we are in looking at the initial procedures and looking at the X-rays and explaining where we are. And we both agree that there is nothing surgically that can be done for this patient. And, again, trying to do something -- there is no tendon

Q. May of 2011, May 18, 2011.
A. Okay. So it's three months. Okay. Just wanted to make sure that we were three months past the revision date when she dislocated. Okay.
Q. Okay. Take a look, please, at Exhibit 12. This is again another ER note. If you look under triage.
A. Okay.
Q. A few lines down it starts, "chief complaint quote to nurse: Patient states I was at home looking at television sitting in a 90-degree angle and leaning forward, and I heard a pop to my left hip." Do you see that?
A. Yes.
Q. So here she is at a 90-degree angle and she takes her hip past 90 degrees when she moves forward, correct?
MR. WOOL: Object to form. It doesn't say hip.
MS. BUSBY: Counsel. Object to form is sufficient.
MR. WOOL: Well, if you stop misleading the witness and trying to imply things that the document doesn't say, we won't have a problem.
MS. BUSBY: Counsel, if you stop coaching the witness, we won't have to call the judge.

BY MS. BUSBY:
Q. Doctor, would you agree with me that description describes the patient who has moved her hip past 90 degrees?
A. I would not.
Q. Okay. Doctor, do you hold the opinion that Ms. Bayes was compliant with postoperative hip precautions?
A. I would because every indication of everyone that was an actual -- involved in her surgical care says that she was compliant, that she worked hard and diligently with her physical therapy, that she understood her precautions, and that those hip precautions were thoroughly explained to her.
I think the -- I'm very glad that you put that first dislocation because now we've clearly established that she dislocated, unfortunately, the start of her series of dislocations happens during -- after the three-month period of time. This is not an acute or subacute time frame.
So it's after that three-month period of time where the hip in the normal set of circumstance nonmetal-on-metal including revisions would be stable. So I'm glad that you put that up so we can clarify because the line of the questioning was that she had

dislocated in the acute or subacute period of time. So I thank you for that.
Q. Well, in fairness, Dr. Kantor, she was revised on March 28, 2011 for the first time, correct?
A. March 28, 2011. Correct. What is her next dislocation?
Q. May 14, 2011, seven weeks post op.
A. Okay.
Q. And then she dislocated again four days later and underwent her second revision.
A. Correct.
Q. So she --
A. So she --
Q. Would you characterize seven weeks as the acute postoperative period?
A. Yes. I mean, before I even knew those dates I told you that the postoperative period for the acute was -- again, this are standard recognized time frames -- acute meaning operative date to seven to 10 days, and then operative date to the six-week period of time. So she is beyond that six-week period of time.
Q. Did you review Dr. Lewallen's notes form the Mayo Clinic, Dr. Kantor?
A. I did. I did.
Q. Okay.

MS. BUSBY: Tiffany, could you please put up Dr. Lewallen's March 13, 2015.
(Defense Exhibit No. 13 was marked for identification.)
MS. RIFFER: Yes. It's loading now. Just one second.
MS. BUSBY: Excellent. That will be, for the record, that will be Exhibit 13.
BY MS. BUSBY:
Q. And, Dr. Kantor, I think you said you thought you may have met Dr. Lewallen?
A. I believe I met him at a hip conference, yes.
Q. Okay.
MS. RIFFER: It's loaded, sorry.
MS. BUSBY: Thank you, Tiffany. That's all right.
BY MS. BUSBY:
Q. He is a fairly well-known orthopedic surgeon, correct?
A. I don't --
MR. WOOL: Object to form.
A. I don't know that. I know he is published. I don't know how fairly well-known he is.

BY MS. BUSBY:
Q. Did you know that Dr. Lewallen is the current president of the Orthopedic Research and Education Foundation?
A. I did not.
Q. Did you know that Dr. Lewallen is the medical director and hip society representative for the American Joint Replacement Registry?
MR. WOOL: Object to form.
A. I did not. I did not know that we had an established joint registry functioning as we speak.
BY MS. BUSBY:
Q. My copy of the Exhibit 13 is still loading, are you able to access yours, Doctor?
A. Yes.
Q. Okay. Bear with me a moment while my system catches up.
While we wait for that to load, Dr. Kantor, do you know how Ms. Bayes came to see Dr. Lewallen at the Mayo Clinic?
A. I believe she was referred to the Mayo Clinic and to Lewallen specifically by Nunley. I think that was the -- or possibly because of the son as well as Nunley. But I don't know who made the phone calls, who made the contacts for the consultation.

Q. Okay. Fair enough. I'm still struggling a bit with access. I apologize for the delay.
Looking at Dr. Lewallen's note, which we've marked as Exhibit Number 13, this is just a two-page note, and this is something you reviewed in the course of developing your opinions?
A. Yes.
Q. Okay. Dr. Lewallen discusses her history of damage musculature from adverse local tissue reaction and the fact that she was ultimately converted to a dual mobility articulation, correct?
A. That's correct.
Q. Okay. Dr. Lewallen has in his history of present illness, about a third of the way down, he states, "we have a copy of the operative report and it is clear that at the same time a transfer of a portion of the gluteus maximum to trochanter was accomplished to try to restore her abductor power. And, in fact, this has been remarkably successful." Did I read that correctly?
A. You read it correctly, but it's incorrect.
Q. That was my next question, sir.
Do you disagree with Dr. Lewallen's assessment?
A. Most definitely.
Q. On what basis do you disagree with

Dr. Lewallen?
A. Well, why don't you read the operative report by the man who supposedly transferred fibers to the -- muscle fibers to the greater trochanter after debriding to bleeding bone, to bleeding bone. It's not a tendon transfer. There was nothing -- there was no fixation used on the X-ray to fix anything. He simply transferred a few fibers muscle -- I believe the term is muscle fibers, if I pull up the op report.
Q. Okay. So Dr. Kantor, I just want to be clear on what the nature of your objection is.
MR. WOOL: Counsel, I don't think he was done with his answer. He was pulling up that report to take a look to finish the answer.
MS. BUSBY: I understand that, Counsel, and I'm trying to make sure we are moving things along.
BY MS. BUSBY:
Q. Dr. Kantor, I want to make sure I understand. Do you disagree with his characterization of the operative report or do you disagree with his characterization that the procedure was successful?
A. Well, it obviously isn't successful because she continues to dislocate so you know that. And it's not dictated in the operative report that the tendon was

transferred to the greater trochanter. And the last person that operated on the patient, which is Dr. Mudd on 8/19/17 gives a clear indication that there is absolutely nothing attached to the greater trochanter, nothing.
So we know it's not successful because the tendon transfer wasn't carried out. There was simply a few, quote, muscle fibers to try to get an attachment. She dislocates. She dislocates repeatedly. And then one month later it describes that the condition of the greater trochanter was nothing being attached to it. As a matter of fact, I'm looking at this description, I'm looking up -- I'm reading now the last operative procedure, the last person to visibly see this.
Q. Can you give us the date, sir, can you give us the date of the document from which you are reading?
A. 8/19/2019, Dr. Christopher Mudd. Second page, gluteus maximus muscle was essentially fibrotic. At this point in time there was some capsule, synovial fluid. There was no soft tissue attached to the greater trochanter posteriorly, superiorly, and very sparsely anteriorly. It is truly abductor deficient with essentially a bald trochanter and essentially a naked capsule.
In other words, the bald trochanter, there is nothing attached to it. He is the last person that

operated on it. He is the last person that visualized it and there is nothing attached to the greater trochanter, which is what you would expect. And it's certainly not a successful procedure considering, number one, it wasn't the procedure done, there was never a tendon transfer done, it's never described in the op report, it's an extensive operative procedure because I've done it. It's not described in the operative report. It's not described in the listing of what was done. It's not charged for the patient in terms of billing charged. And the last surgeon that operated on her certainly doesn't see it there because it's nonexistent. There is nothing attached to the greater trochanter. Trochanter is bald.

Q. Okay. Dr. Kantor, Dr. Lewallen's note is from March 2015, correct?

A. Correct.

Q. And you just read from Dr. Mudd's operative report from August of 2017, so almost two and a half years later, correct?

A. Mudd's operative report is actually from, I believe, from August '17.

Q. Yes. 2017, sir, correct?

A. That's correct. I thought you said 2019.

Q. No, sir. I'm sorry if I misspoke.

And so that -- in that two-year period of

time Ms. Bayes continued to dislocate, correct?

A. Yes.

Q. And in that -- and as we discussed before dislocation themselves can cause damage to the tissue, correct?

A. They can.

Q. I'd like you to focus on Dr. Lewallen's note from March 13, 2015.

A. Let's get it. It's in front of me. Why don't you ask me what you need to know.

Q. Okay. Dr. Lewallen notes in his history, "we talked with her in detail about the events surrounding the dislocation, and all of these have occurred with her flexed at the waist and with her knees in a relatively neutral or abductive position often with rotation of the trunk towards the affected left side, which basically results in an abducted and internally rotated position in addition to the flexion producing the recurrent dislocations." Did I read that correctly?

A. You did.

Q. And do you disagree with his observation?

A. Well, I don't think, you know, the idea that you are going to blame the patient for her positional dislocations is kind of absurd. I think -- and I'd like point out for the record, I believe that Dr.

Lewallen has disclosures in terms of money received from your company, which I think is important. That comes into play here.

I do find it somewhat offensive -- and I have to tell you this, I know this is your job, as a physician talking about a woman whose life has been ruined by this, I find it somewhat offensive that someone would attempt to blame the patient, including the dislocation that occurred in church, on position -- malpositioning of her limb and doing something wrong to create what has happened here. I find that extremely, extremely offensive.

MS. BUSBY: Objection. Move to strike. Nonresponsive.

BY MS. BUSBY:

Q. Doctor, my question is simply this: Do you disagree with Dr. Lewallen's observation?

A. I disagree with Dr. Lewallen's observations. There may have been a time in one of her 16 or 18 dislocations that maybe she did something in terms of going beyond what was described, but everything that this woman has done in terms of dislocations has been done within activities of daily living. This is not someone doing gymnastics. Certainly, even you, Counsel, wouldn't consider going to church to be some kind of a

reckless activity.

So I don't agree with it. I think it's a very self-serving -- it's a very self-serving letter trying to justify what has happened to this patient and the fact that this patient has sustained all these dislocations because she has not followed advice. And it's contrary to the records because every physician, every physical therapist that I have seen has documented that they have explained to her what the dislocation precautions are, that she understands them, and she is compliant and is attempting to carry them out.

Q. Referring back to the documents, Dr. Kantor, at the bottom of that page under physical examination Dr. Lewallen writes, "musculoskeletal: On examination she walks with a nonantalgic gait, and has remarkably normal hip abductor strength better than antigravity on manual testing, perhaps very slightly weak but only slightly so." Did I read that correctly?

A. You did.

Q. Do you disagree with Dr. Lewallen's physical examination of Ms. Bayes?

A. I disagree completely. Number one, I would question, did Dr. Lewallen dictate this or was this dictated by someone else. Number two, I have never in all my years in orthopedics, and I have published on gait

analysis, it's one of my areas of specialty, I have never seen a patient that has absolutely no abductor be able to walk with a normal or near normal gait.

And it just does not make any anatomical sense and it defies -- it defies any anatomical truth. So I don't know how anybody without an abductor can walk without a Trendelenburg type of a gait, which is pathognomonic with this type of problem, with metallosis and destruction of the abductor muscle group.

Q. I understand. And to confirm, Dr. Kantor, you've not had the opportunity to examine Ms. Bayes?

MR. WOOL: Object to form.

A. I have not.

BY MS. BUSBY:

Q. And you did not have the opportunity to examine Ms. Bayes in 2015?

MR. WOOL: Object to form.

A. I haven't examined her at all. You know that.

BY MS. BUSBY:

Q. Okay. Let's look down under impression, and Dr. Lewallen writes, "discussed with the patient. I told her that after some detailed discussion and review of her circumstances I think the first step would be for her to, for the very first time, be compliant with

reasonable restrictions for her hip." Did I read that correctly, sir?

A. You did.

Q. Do you disagree with Dr. Lewallen's assessment under impression after his physical examination of Ms. Bayes?

A. I do.

Q. And what is the basis for that disagreement?

A. Basis for that disagreement is nowhere in her records other than this self-serving report of Dr. Lewallen who is employed by your company, receives funding from your company, there is no record that this patient is a noncompliant patient or who has done anything wrong. And that includes multiple physical therapists and multiple physicians on multiple occasions, and it's well-documented in the literature -- I'm sorry, well-documented in her chart.

Q. So, Dr. Kantor, am I understanding you correctly that you believe Dr. Lewallen issued this report because of some monetary benefit he was receiving from Zimmer Biomet?

MR. WOOL: Object to form.

A. You should ask Dr. Lewallen that.

BY MS. BUSBY:

Q. Sir, you just said this is a doctor who is receiving benefits from my client. So I'd like to know what evidence you have that Dr. Lewallen was receiving some benefit from my client at the time that he wrote this report about his patient?

MR. WOOL: Counsel, are you going to argue with the witness?

MS. BUSBY: No, I'm asking him questions, Counsel.

BY MS. BUSBY:

Q. Go ahead, Doctor. You can answer.

A. Because his disclosure statements states that he receives money and funding from your company, from the people that are paying you are also paying him.

Q. When did he receive money from Zimmer Biomet, sir?

A. Dr. Lewallen has been receiving money from Zimmer Biomet for a number of years. If you look at the disclosures related to his article, it will document it.

Q. You received funding from Johnson & Johnson DePuy for two decades, correct, sir?

A. I did.

Q. You did not allow that funding to interfere with your analysis and treatment of your patient, did

you?

A. I certainly did not. Maybe I'm different than Dr. Lewallen.

Q. On what basis do you have for claiming that Dr. Lewallen's care and treatment of his patient was inappropriate or biased?

MR. WOOL: Object to form. Asked and answered.

A. Well, first of all, he is not treating the patient, he saw her in evaluation. And in terms of this evaluation I do not see, number one, is not a correct dictation. Now again, maybe he did not do the dictation. The dictation is not correct in terms of what was done to this patient. This patient has never had a tendon transfer. This patient in every evaluation and every operative report that we looked at states the damage. You can see the pictures.

I have a hard time even believing that a gait analysis in a Trendelenburg test was performed on this patient because I have never seen a patient who is completely deficient on the abductor muscle group being able to walk without a limp or without abductor or Trendelenburg gait. It almost defies -- it defies logic.

And either he didn't examine her or he is misleading people in terms of what he is putting in here.

Now, you should ask him if he examined her. You should ask him if he read these other operative reports. But the patient obviously doesn't have an abductor, and I find it amazing that she has despite restoration of abductor strength with the gluteus maximus -- he also notes that the gluteus maximus is severely diseased and fibrotic and it hasn't been transferred to the greater trochanter.

So there is something that is not right about this op report, the operative reports and this dictation. It does not coincide with, number one, the operative pictures. Number two, the pathology pictures that you are seeing documented from the first revision. The multiple descriptions of the lack and the deterioration of the abductor to the point that it's completely detached. The fact that there is nothing attached that can even be found.

So I don't know how you can make this statement when you have no muscle tendon transfer restoration of abductor strength with gluteus maximus transfer when she hasn't had one.

BY MS. BUSBY:

Q. If you would scroll down to the bottom of that second page, the very last sign, sir, says, electronically signed 17th March, 2015, 8:08 by Dr. D.G.

Lewallen; do you see that, sir?

A. I see it.

Q. Does that indicate to you that Dr. Lewallen reviewed and signed this document?

A. He apparently electronically signed this document, whether he read it or not I don't know. But there is nothing about this dictation that -- it's almost as if the patient that I'm reading about, the patient that's had all these operations, all these findings, it's almost like it's a different patient. You should probably send him my dictation -- I mean, my deposition with these questions I have in conjunction with all these operative reports and the pictures, and see if he would again say this is the case.

Because unless we are talking about a different patient this does not make any sense to me. Now, maybe he was busy, maybe he just electronically signed, like unfortunately a lot of us do, without reading it. It was probably dictated by a resident or a fellow. But I have a hard time putting this impression, this consultation report with this patient. I really do. It just doesn't make any sense.

Q. And you do understand that Dr. Lewallen has not been retained to provide an expert opinion by either party in this case, correct, Dr. Kantor?

MR. WOOL: Object to form.

A. I didn't know that at all until you just stated it.

BY MS. BUSBY:

Q. Now, there is a note in Dr. Lewallen's note that he does make reference to the fact that she had her right hip revised in 2014. And then at that point she was not having any issues or complaints with respect to her right hip; do you agree with that?

MR. WOOL: Object to form.

A. It appears so.

BY MS. BUSBY:

Q. Do you have any information that Ms. Bayes has gone on to have any problems right hip post revision?

A. I do not.

Q. And she'd had that Magnum device in her right hip for approximately six and a half years; is that correct?

A. That's correct.

Q. Okay. You refer in your report to the deposition [sic] of the right hip as being both appropriate and timely and undertaken to remove the index metal-on-metal THA on the right in an effort to prevent further tissue destruction experienced on the left THA; is that correct, sir?

MR. WOOL: Object to the form.

A. That is exactly right.

BY MS. BUSBY:

Q. And when you say it was a timely revision, you used the word timely. Tell me why you used that word and what you mean by that.

A. Well, as you'll see from the documentation that we are going to send you with the updates on treatment algorithms for this, if we timely had gone through the surgical -- the surgical photographs that were sent to you that we'll be discussing in trial, you'll see why now the treatment course is the quicker you can get in to get these aggressive destructive pseudotumors out the better off you are, even if the patient is clinically asymptomatic.

If you look at the picture which we will then go over at trial and I will show you a surgical intervention at an earlier period of time, a timely intervention so you are available to resect the pseudotumor before it destroys the capsule, the external rotators, and the most importantly abductor muscle group, which interestingly is the only muscle group that provides abductor and inherent stability to the hip to maintain it within the joint articulation and prevent it from dislocating.